

Economic Impact/Alternative Use

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Council on Hospital & Institutional Dental Serv.

P10439.7

Licensed by: Minnesota Department of Health
Minnesota Department of Public Welfare -
Rules 3, 34, 35, and 36

Certified by: Department of Health & Human Services
for Medicare (Title XVIII)
Minnesota Department of Health
for Medicaid (Title XIX)

Member of: Minnesota Hospital Association

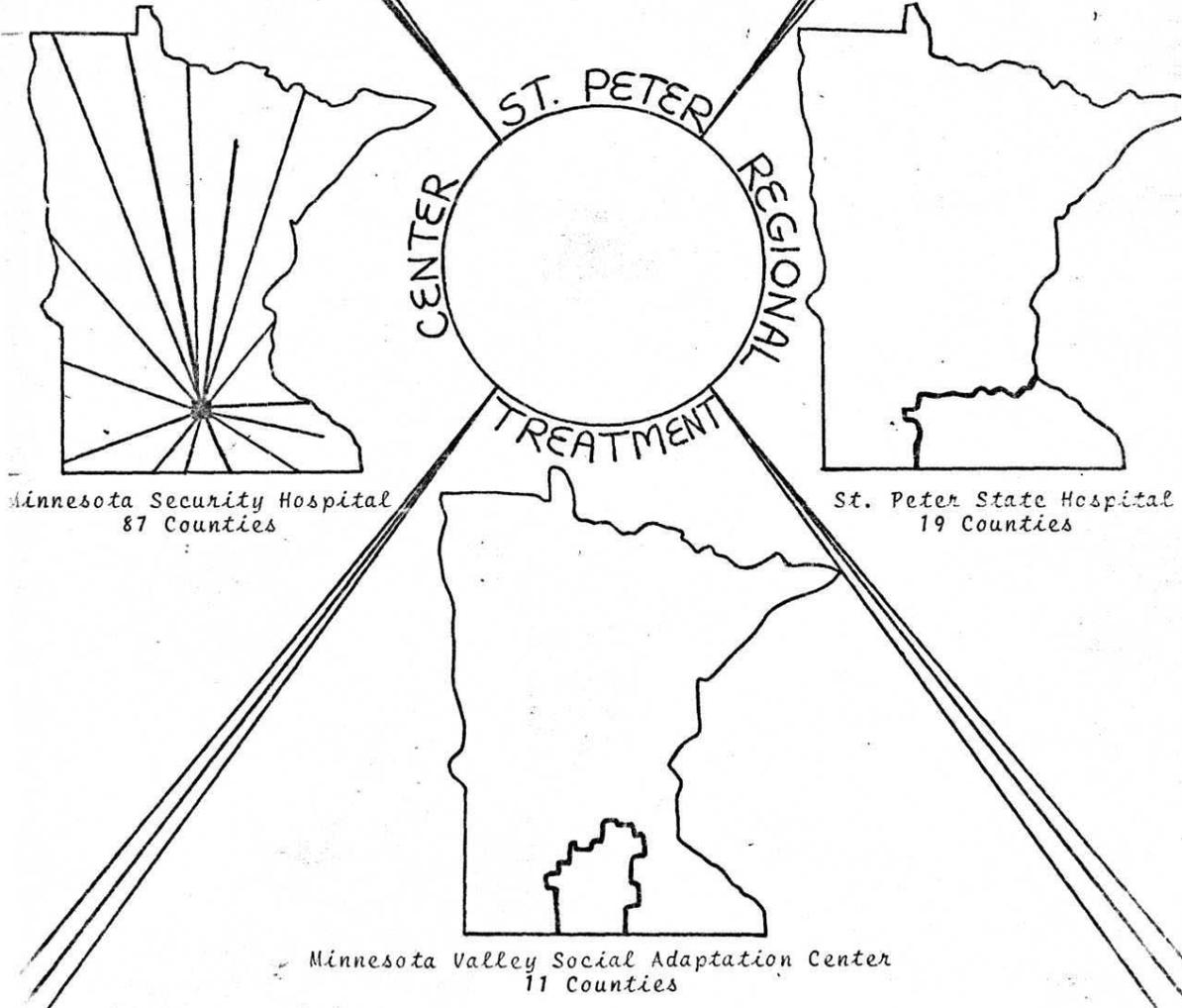


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I. ST. PETER STATE HOSPITAL

In addressing the so-called "continuum of care", the state hospital system has been considered the forerunner and bastion for the provision of mental health services in the state of Minnesota. As societal expectations and times have changed, there have been a number of new developments and different methods of approaching the mental health needs of the persons with mental illnesses and developmental disabilities. These new approaches have in many ways met some of the needs which were, and are, prevalent in today's society. Resulting from these new approaches has been a change in the role and delivery of service of the modern state hospital (regional treatment center).

The hospital of today is seen as a regional resource for those types and degrees of mental illness or disability which cannot be effectively treated by existing community resources. The St. Peter State Hospital is a classic example of this ongoing evolution as follows:

1. The St. Peter State Hospital was the first institution established in the state of Minnesota for the care and treatment of the mentally ill person, and has been in existence since 1865.
2. As a part of the history of the St. Peter State Hospital, treatment components for the chemically dependent, mentally retarded and a forensic facility for the mentally ill and dangerous have been added to the original facility's role and purpose.
3. The St. Peter State Hospital is by its unique organization a regional facility for the mentally retarded for Region IX, a multi-regional treatment facility for the mentally ill and chemically dependent for Regions IX and X, and a statewide treatment and evaluation facility for the mentally ill and dangerous for the entire state of Minnesota.

4. The St. Peter State Hospital has a present licensed bed capacity of 674, and currently is operating at over 90% occupancy.
5. During the past 12 months, the St. Peter State Hospital has absorbed the admission and treatment responsibilities of the former Rochester State Hospital; and as a result, has increased its admission rate by 16%.
6. The St. Peter State Hospital operates the only forensic psychiatric unit (Minnesota Security Hospital) in the state of Minnesota and has just completed occupancy of a new \$10 million, modern, and secure psychiatric facility.
7. The St. Peter State Hospital is licensed by the Department of Public Welfare under Rule 3, 34, 35, and 36; and is the first state institution in Minnesota to be accredited by the Joint Commission on Accreditation of Hospitals for a three-year period.
8. Almost 50% of the hospital's annual budget, \$16 million, is reimbursed to the state of Minnesota, General Revenue Fund, through Federal reimbursement and third party payees.
9. With over 700 employees, the St. Peter State Hospital is St. Peter's largest employer and accounts for 32% of all wages paid in the city of St. Peter and approximately 10% of all wages in Nicollet County.
10. While current statistics indicate that the admissions to the St. Peter State Hospital have increased significantly during the past year, our Program Evaluation Department indicates that we have continued to reduce recidivism to a current average of 30% for the mentally ill and 22% for the chemically dependent; we have maintained a median length

of stay of 108 days for the mentally ill and an average of 29.5 days for the chemically dependent.

While this report addresses itself to the impact of closure of a state hospital, it is evident with an increasing population growth, decreased federal and state financial assistance, that communities are and will continue to be unable to respond to the acute and severely psychotic individuals' needs, as well as to those with severe and profound mental disabilities. Our contacts with the counties in our catchment area, with community support facilities, and with the general public confirm what we as a regional hospital are experiencing; namely, that there is an ever-increasing need for a state facility that is well-staffed and operated to provide for the care of citizens who are unable to receive specialized treatment anywhere else in the community.

The St. Peter Regional Treatment Center, i.e. St. Peter State Hospital, is a unique organization within the state hospital system. As the first state hospital in Minnesota, the mental illness and chemically dependent programs of 234 beds are organized under a Medical Director, and called the St. Peter State Hospital. Subsequently, the Legislature established, as a separate legal entity on the campus, the Minnesota Security Hospital, a unit for the mentally ill and dangerous patient of 236 beds. This unit is headed by a separate Medical Director. Finally, a separate unit of 204 beds for the mentally retarded was established and called the Minnesota Valley Social Adaptation Center. This unit is directed by a Program Director. These three units are governed by a Chief Executive Officer under the umbrella organization of the St. Peter Regional Treatment Center, which provides for a sharing of a common administration and governance and a more effective utilization of support services.

For the purposes of this report, the material presented will, be by this organizational structure.

II. ST. PETER STATE HOSPITAL

St. Peter State Hospital, one of three treatment facilities on the St. Peter Regional Treatment Center, is a 234 bed general psychiatric hospital offering treatment services to the mentally ill, including the psychogeriatric population, and the chemically dependent. The 19 counties served include:

Nicollet	Faribault	Dodge
Brown	Rice	Mower
Watonwan	Waseca	Wabasha
Martin	Freeborn	Olmsted
LeSueur	Steele	Fillmore
Blue Earth	Goodhue	Winona
	Houston	

St. Peter State Hospital operates on a multi-discipline Treatment Team approach on all units and is organized on a unit/department basis which functions very successfully. All treatment modalities are available including psychiatric/ medical, psychological, social services, vocational, nursing, rehabilitation (including a broad work program), behavior analysis, complete medical records services, and special rehabilitative services by referral..

St. Peter State Hospital is the only state psychiatric facility to receive a full three (3) year accreditation from the Joint Commission on the Accreditation of Hospitals; SPSH also continued its full licensure under DPW Rules 35 (chemical dependency) and 36 (mental illness) as well as certification by the Minnesota Department of Health including HEW Titles 18 and 19. The present capacity of the hospital is utilized at a 96+ - 98+% rate on a continuous basis since January 1982, and these figures will undoubtedly hold constant since the existing catchment area includes a population of 60.0,000+. See "Appendix A for demographic data reflecting projected county population growth and decrease projections, as well as Appendices B, D, and F for admission and discharge data.

A. Mental Illness Program

With St. Peter State Hospital not serving the needs of mentally ill persons, those in need would have to be served by Willmar and Fergus Falls State Hospitals. As St. Peter serves a 19 county area, the round trip distance for a county, if St. Peter were bypassed, would be an additional four (4) hours to Willmar and 7-8 hours if Fergus Falls were utilized.

Given the greater distance, it would be safe to assume the cost to the county of referral would be reflected. Further with financial limitations, more mentally ill in need of acute or chronic care would be allowed to remain in the community. The consequence would seem to be the likelihood of more violent behaviors and crimes. As a response, jails and psychiatric wards of hospitals (local) would have to be utilized. Jails, traditionally, make minimal distinction between the criminal and the mentally ill, and this would be detrimental to the needs of persons in need of psychiatric care. Local hospitals with psychiatric units tend to work with the acute care mentally ill and one who has financial means to pay for such care. The needy mentally ill person would probably be excluded.

The distance from the county of referral would seriously hinder reintroducing the resident back into the community. This would occur because the community resources would be far removed from the serving hospital. County social workers would also be geographically removed from the serving hospital and consequently would have minimal contact with the resident and the treatment team. This combination would reduce the speed of discharge to the community and would reduce the possibility of utilizing the most beneficial placement. This is because group homes or halfway houses funded by the County of referral are generally located in that county. It will be more expensive for the resident, in terms of time and money, to commute to the interview, pre-screening, and eventual placement.

An integral part of reintroducing the resident back into his community is to develop a positive relationship with the family of the client. This includes, at times, family counseling sessions. This is essential because it provides the resident with a base of support when they leave the hospital. With the resident now removed from his county or residence, such sessions are expensive and time consuming for the family. With the resident in the two aforementioned hospitals, the distance would make such sessions impractical. This, then, would have a significant impact on discharges.

The distance factor would tend to impact upon the length of stay. We are well aware that attempts need to be made to discharge residents as they peak. To be -unable to do so encourages greater likelihood of institutionalization and return, to custodial care.

If distance from the serving county does become a factor in determining whether to place a mentally ill adult, then we must be reminded of the following:

That previous reduced reliance on the state hospital for all services for the chronically mentally ill patients has made evident the inadequacy of the community's ability to provide for their basic human needs for shelter, food, and clothing, as well as income, employment, and meaningful daily activities. Furthermore, opportunities for needed services, including health, mental health, rehabilitation, and education, have been insufficient. These people can be seen wandering the streets in many cities in the nation today.

Approximately 20 patients (mentally ill) are awaiting jobs and/or community placement at this time. They have no resources or family support group. If the hospital were not a resource to them, they would be conceivably without food or shelter at this time or on the welfare roles.

If St. Peter State Hospital did not house mentally ill adults, then the possibility would exist that the same amount of mentally ill adults would have to be provided for in fewer facilities. This, by the very nature of it being overcrowded, would reduce the potential for individualizing programs based on individual resident need and would create an environment more indicative of "warehousing." Further, it would greater isolate the mentally ill patient by creating "pockets" of residents who are mentally ill in smaller areas. There are strong indications that if the public is allowed to interact with the mentally ill in situations that allow the mentally ill person to be perceived as "normal," the attitudes of the public will shift in a positive direction. This has certainly been the case at SPSH.

Another segment impacted by St. Peter State Hospital's not serving the mentally ill would be those programs that work with that population. They include Horizon Homes I and II and Mankato Rehabilitation Center. They draw heavily on our population that are nearing discharge.

The Mentally ill programs utilize volunteers from colleges (Gustavus Adolphus) as well as social clubs in the community. These participants provide needed one-to-one special attention to residents who don't have families, but more importantly it brings the community closer to the mentally ill adult. It provides the community with a more human understanding of the life and needs of the mentally ill. Any volunteer activity, i.e., visiting hospitals, helping in rehabilitation, will lead to greater support for and greater advances in positive mental health. This may be even more so than intellectually oriented mental health programs.

St. Peter' State Hospital has established an effective treatment program which is an integral part of the community treatment program. It provides highly specialized services for the mentally ill, serves as a backup treatment center for overburdened community programs or for prolonged treatment of persons who have not responded to other community treatment programs, and provides services to persons who are unable to pay for services within the community mental health system. St. Peter State Hospital continues to serve a meaningful function in the mental health system, treating chronically mentally ill persons and other special groups, in part to meet clinical needs and in part to fill a critical gap due to the pervasive lack of alternatives as well as providing acute care and specialized services.

B. Chemical Dependency Program

The following report attempts to outline the impact of J.C.D.U. on the 19 county catchment area designated by the Department of Public Welfare to St. Peter State Hospital. The report is meant to be a statement regarding anticipated ramifications on the client, county, and regional area in the event the services provided by J.C.D.U. were no longer available.

Johnson Chemical Dependency Unit accepts clients from a variety of referral sources: (1) commitments; (2) Minnesota Department of Public Safety (as requirement for restoration of driving privileges); (3) secure correctional facilities recommended as transitional phase in re-entry to community; (4) in lieu of jail/condition of probation per recommendation of correctional agent; (5) county social services agency; (6) self-referral.

J.C.D.U. treats the indigent, chronic, disabled (i.e. those with emotional, physical, functional handicaps); most of whom would be precluded from participation in private treatment programs by virtue of the existing conditions.

J.C.D.U. provides the following services in addition to primary and extended care programming:

- Family Program (education, problem identification, referrals)
- Aftercare (free of charge, available to clients/families on weekly basis, available to persons residing in catchment area who have completed any CD. treatment program)
- AA/Alanon (open to public twice weekly)
- Follow up (monthly telephone contact for up to 2 years following discharge)
- Public Relations (staff is available to speak to service, and other community clubs upon request with inclusion of 11 counties in catchment area within the past year; staff has met with county personnel in an effort to establish constructive working relationships and enhance continuum of care)
- Division of Vocational Rehabilitation services as part of comprehensive team effort
- Information and Referral (sometimes first contact for persons requesting information regarding chemical dependency and/or treatment; provide community resource information to clients and C.D. professionals in southern Minnesota area)
- C.D. Assessments and Treatment for Residents of Other Units on S.P.R.T.C. Campus

J.C.D.U. is involved in a longitudinal evaluation of the program. The long term goal of the study is to provide the data necessary to tailor a C.D. program which directly responds to the needs of the persons served and enables them to return to and remain in the community as productive members. A literature search* indicates the uniqueness of this project

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in that it is state hospital based, longitudinal, and a developmental as well as summative process.

Private treatment facilities (both in/out patient) are available in the area. However, cost is prohibitive for indigent persons without insurance. SPSH Reimbursement Office reports that 80% of persons admitted for treatment at J.C.D.U. would not be eligible for services provided by private facilities due to lack of personal funds and county funding constraints. Persons unable to afford the cost and given no alternative to private treatment could conceivably be denied treatment altogether.

Other state institutions can serve the same type of population as J.C.D.U.; however, distance, and related factors, are prohibitive. The furthest point in J.C.D.U. catchment area is approximately 150 miles from St. Peter. Referral to W.S.H. would place an additional 100 miles on this figure and to F.F.S.H., an additional 200 miles. Problems inherent in the added distance include:

- travel time and transportation cost to family and county personnel
- transporting personnell's objection (i.e. Sheriff's Office)
- difficulty coordinating community placement/continuum of care due to distance and unfamiliarity

Given these prohibitive factors, it is conceivable that a percentage of prospective admissions would simply elect to forego treatment.

In sum, J.C.D.U. provides services to a number of agencies and individuals within the Region. Discontinuation of these services would not likely result in a transfer of responsibility to other sources; rather, county budget constraints and pragmatic obstacles involving the distance factor would preclude the provision of quality services to the chemically dependent.

C. Psychogeriatric Program

This unit serves the 19 county area of southern and southeastern Minnesota with a population of 600,000+. The Geriatric Unit has 34 beds, and the amount of total nursing care varies with admissions. The types of problems dealt with include: Schizophrenia in elderly persons as well as all forms of Organic Brain Disease. This population requires a high level of physical care and supervision as many of these patients require bathing, feeding, dressing, toileting, activity motivation, social interaction by others, and environmental stimulation. The Mentally ill Geriatric Unit admits and discharges approximately 25 persons per year, and there is no comparable alternative for the population served in southern Minnesota.

As studies have shown, moving an elderly person from familiar surroundings has a very traumatic impact on both -the physical and mental health of those person's. The geriatric program attempts to stabilize and improve the physical and mental status of its patients and return them to a familiar environment. Family visits also facilitate this process. Closing this unit would mean the geriatric patient who needed psychiatric care would need to be treated at a state facility, i.e., Willmar, Moose Lake, or Fergus Falls, which are many added miles from home as most cannot afford private care in their own geographic area. This would decrease if not eliminate family support through visits and participation in treatment and discharge planning. It would also mean a rise in costs to the counties with decreased county involvement in treatment and discharge planning. If placement does not occur in the patient's home area, aftercare and follow up would be non-existent because of the distance involved.'

Many of the patients PECU serves have been unable to maintain themselves in the community due to their mental illness. They have not even been able to maintain placements in nursing homes due to severe behavioral problems. Currently, community resources available to the elderly persons in need of treatment for mental illness are practically nonexistent. The two state nursing homes are usually filled to capacity, and the other viable resource, mental health centers, are not only usually under-funded, but the geriatric population historically constitutes a very small percentage of their clients.

III. MINNESOTA VALLEY SOCIAL ADAPTATION CENTER

Minnesota Valley Social Adaptation Center was developed in 1968 on the St. Peter State Hospital campus utilizing a number of buildings formerly used to care for the mentally ill. The Center was established to provide care and training for ambulatory mentally retarded adults from the geographic area now referred to as Region 9 and 8, and also Scott and Carver counties in Region 11. The Center was the first major residential program for the retarded to be developed in a hospital for the mentally ill. Six other hospitals in the State system eventually established multiple programs for MI-MR and CD clients.

This major change in Minnesota's State Hospital system occurred at a time when deinstitutionalization of the mentally ill was causing a rapid decline in the hospitalized population of mentally ill. Deinstitutionalization of the mentally retarded had not yet begun and the institutionalized mentally retarded population was at its apex. The three MR institutions (Faribault, Cambridge and Brainerd) were disturbingly overcrowded. The public was becoming aware of the dehumanizing conditions provided the retarded and efforts had begun to examine state hospital programs and improve the conditions that existed. Utilizing available bed space vacated by the placement of the mentally ill seemed logical.

The establishment of regional state facilities for the mentally retarded preceded the deinstitutionalization movement of the retarded. Since the Late 1960's the numbers of institutionalized MR's as well as the mentally ill have dramatically been reduced. During this period the development of community services for the mentally retarded occurred rapidly. In 1971 the population of MVSAC approached 400, whereas the current population (6-1-82) is 183 and two regional state MR facilities in Southern Minnesota have been closed, Rochester and Hastings. The presence of regional MR facilities obviously affected this rapid decline as communities became more readily aware of their hospitalized clients and regional facility staff were frequently key personnel in community service development efforts.

Of the 183 residents at MVSAC, 163 have residence in the MVSAC receiving district, and the other 20 are from counties of residence

outside of our receiving district. The majority of these residents have remained at MVSAC due to family requests because parents live in our region or for other personal reasons.

COUNTY UTILI ZATION			
Region IX	MVSAC (6/1/82)	Region XI	MVSAC (6/1/82)
Blue Earth	34	Carver	10
Brown	22	Scott	15
Faribault	20		
LeSueur	17	Others	20
Martin	9		
Nicollet	12		
Sibley	12		
Waseca	5		
Watonwan	7		

During the past five years (1977-81) 43 residents have been admitted from our receiving area or an average of 8 admissions per year. This number does not include transfers from other hospitals or respite care admissions. These are long-term care admissions. During this same period, 97 residents were discharged to the community or an average of 19 per year. This number again does not include respite care, deaths or transfers. The net reduction in population at MVSAC has averaged about 10 per year. At this present rate of reduction, MVSAC over the next five years would be at a population of 133 which is very close to the required population reduction specified by the Welsch-Noot Consent Decree.

Within MVSAC's eleven county receiving area there are currently 409 ICF-MR beds and additionally a growing number of SILS placement opportunities.

ICF-MR / RULE 34 LICENSED BEDS	
Blue Earth	95
Brown	28
Faribault	19
LeSueur	14
Martin	50
Nicollet	0
Sibley	15
Waseca	18
Watonwan	0
Carver	112
Scott	

There are two proposed projects currently approved by DPW which would add 31 additional ICF-MR beds within the next year. State hospital populations today consist primarily of the most severely handicapped individuals. The majority of the borderline, mild and moderately retarded individuals have moved in the community. State hospitals also are experiencing fewer admissions due to the availability of community programs. The individuals who are admitted today primarily present severe behavioral problems. The severity of the problems is currently beyond the coping ability of the community programs. However, the ability of state hospital programs to deal with the behavior disordered client has improved significantly; therefore, admission of this type of client is seen as being the service of choice, not of last resort. In some cases, state hospital admission is seen as being essential due to lack of other alternatives, but only short-term until other community alternatives become available.

The majority of mentally retarded persons being served by community programs are very much dissimilar to the majority of individuals served by the state hospitals. Current literature supported by rather extensive research supports this conclusion. The deinstitutionalization of present state hospital residents will require the development of vastly different community programs than what currently exist. Thus, the impact of closure of MVSAC would require the placement of the MVSAC's residents in other state facilities as the majority of them (72%) are severely and profoundly handicapped.

FUNCTIONAL LEVEL

Borderline Mental Retardation	3	2%
Mild Mental Retardation	10	6%
Moderate Mental Retardation	29	16%
Severe Mental Retardation	61	33%
Profound Mental Retardation	72	39%
Unspecified Mental Retardation	<u>8</u>	<u>4%</u>
	183	100%

If MVSAC were to close, the most appropriate state facilities to receive the Center's residents would be Faribault and Willmar. To many clients and their families, the return to Faribault, and the elements of a larger institution, is seen as undesirable and

counter to improved services and living environments. The development of multi-purpose state hospital programs was publicly accepted as a reform of previously inadequate services. The move to close is predominately accepted for an economical benefit. What will result in terms of better programs and services to the clients is not as easily apparent. Changes in the 1960's held out the promise of improved living environments, enriched staffing complements, and locating clients closer to their homes and families. The closing of MVSAC would seem to diminish those benefits.

Regional facility staff such as at MVSAC have developed the strength of a close working relationship with county social services and human services staff, as well as community residential and day program providers. These relationships have created an environment for effective service to residents and their families. Several factors assist this relationship. Size of the staff group is smaller, thus the community worker is able to get to know Center staff personally. Through frequent contacts, the element of trust develops which fosters better planning of services for the resident. It is more convenient for community staff to get to the regional facility when it is geographically closer. If residents are in large centrally located facilities, it is expected that good community relationships, which are vital to good programs, would be difficult to maintain. The isolation of institutions, long a complaint, would again prevail.

The regional facility is beginning to reach out to be available to assist community agencies in providing service to their clients. The institutions as a resource in this manner is the outgrowth of their regional location and close relationships. Unless large central institutions consciously develop this type of service, community programs will lose a vital support link. The close working relationships that support easier transitions during admission and release of residents will also be gone. Residents will not be served as well as the deinstitutional efforts become much more difficult to implement.

The reform of institutions in Minnesota, which has occurred over the past 15 years, appears to now be in jeopardy if regional facilities such as MVSAC are closed. The ramifications would seem, based on historical experience, to be detrimental to quality

resident care and community service development for the mentally retarded. Economic benefits may, on the surface, appear attractive, yet the results of poorer services may eventually be extremely costly.

IV. MINNESOTA SECURITY HOSPITAL

A. Population Served

Minnesota Security Hospital (MSH) is the only forensic facility in the State of Minnesota which provides specialized evaluation and treatment for mentally ill, mentally ill and dangerous, and sexual offenders, including men and women from age 18 and over. Occasionally, evaluations and treatment is provided to individuals under 18 years of age. This provides the probate and district courts with the advantage of maintaining procedural ties with one facility which the judges can more effectively use in providing for the safe and secure treatment of patients, and for the protection of the community. MSH admits individuals from all 87 counties in Minnesota and occasionally from other states. As of June 2, 1982, there were nine individuals being treated at MSH who are from another state.

If MSH were to be closed, the population from this hospital would have to be redistributed among the remaining state hospitals with a small percentage of the population referred back to corrections and/or courts. This redistribution, in addition to the cost of renovating several state hospitals' buildings (see page 2) to provide security, would also necessitate training and retraining staff to provide the kinds of specialized services necessary to admit, treat, and release these most difficult patients. Further, it would cause a great deal of confusion to the courts to redevelop forensic relationships with six state hospitals. A breakdown by receiving area of the in-house population as of June 2, 1982, for MSH is as follows:

Anoka State Hospital receiving area	76
Brainerd State Hospital receiving area	11
Fergus Falls State Hospital receiving area	13
Moose Lake State Hospital receiving area	43
St. Peter State Hospital receiving area	24
Willmar State Hospital receiving area	16
Non-residents at MSH	9
- Total	192

The programs at MSH are designed specifically for men and women who require a high security environment and intensive, expansive treatment. All areas at the St. Peter Regional Treatment

Center (SPRTC) utilized by patients from MSH have been renovated to provide a high security setting for programming.

There are eight units which provide specialized programs in a high security setting. The eight specialized units are: chemical dependency, low-functioning sexual offender, high-functioning sexual offenders, short-term pre-discharge, therapeutic community, aggressive-acting out behavior, admissions, and women's unit.

Each unit provides a unique combination of treatment modalities for all patients. The following treatment modalities are provided: psychiatric evaluation, psychiatric individual and group counseling, utilizing several psycho-therapeutic models, medical, psychological, social and family counseling, bio-feedback, vocational/work training, industrial-educational, recreational, occupational/activity, community orientation, and academic training.

B. Capacity Lost/Placement of Patients

Should MSH close, the population from this facility would continue to need in-patient psychiatric care in a high security setting. Placement in adult programs at other state hospitals is possible; however, it would be very difficult and costly to duplicate the kinds and quality of services and facility that is presently provided at MSH in six separate state hospitals. There are problems finding qualified staff for one forensic facility; to provide qualified staff in six separate facilities would be extremely difficult.

The other factor which needs to be considered is the cost of constructing a building at each state hospital which would provide a high degree of security. At this time, no other state hospital has such a building. While it may be possible to remodel existing buildings to meet the security needs, our experience in constructing the new building, and attempting to remodel old buildings to house MSH patients, suggests that it may be necessary to construct an entirely new building at each state hospital for these patients who need a high degree of security in both their residential and programming areas.

C. Impact on Patients

MSH is the only forensic facility in the State of Minnesota which provides treatment for the mentally ill and dangerous patient. Patients would have very little, if any, treatment available if MSH were closed and would be deprived of the right to receive treatment. Since there are no similar state or private programs available for these patients, it is conceivable they would end up in a custodial care program and/or in a correctional system. Because of the extreme dangerous-ness of most of the MSH population, distributing them to other state hospitals could result in disastrous problems for both the receiving hospital as well 'as the community at large. For example, it is highly probable that an increase in injuries for patients, staff, and the public would occur without the costly renovations to buildings or new construction,

D. Impact on Counties

Distribution of patients from MSH to other state hospitals would result in severe problems especially for urban counties. Populated counties such as Hennepin, Ramsey, and St. Louis would face the prospect of having their mentally ill and dangerous patients spread out among several of the state hospitals, thereby greatly increasing their case management cost. For example, Hennepin County has approximately 60 patients receiving treatment at MSH. None of the other state hospitals would have the living and program spaces available to accommodate this large of an influx of mentally ill, dangerous, and sex offender patients. This is regardless of whether there is renovation or new construction projected for each state hospital.

E. Impact on Staff

The staff of MSH is unique in that they are specifically trained and experienced for the delivery of treatment services for the special population served. This staff has also had extensive training in security issues and techniques; legal status and commitments especially pertaining to the

mentally ill and dangerous, psychopathic personality, and sex offenders. The professional and direct care staff presently employed at MSH include the following classifications: psychiatrist, physicians, nursing staff, psychologists, social workers, behavior analysts, rehabilitation therapist, vocational counselors, special education teachers, chemical dependency counselors, and attendant guards. Duplicating this same staff at six other state hospitals would be cost prohibitive even if these types of qualified staff could be recruited.

For additional information on impact on staff, refer to appropriate section.

Impact on Community

The closing of MSH would have far-reaching effects on the quantity and quality of educational training sites utilized by many educational institutions in the southern part of the state. Each year approximately 15-30 students are given practicums in forensic treatment appropriate to their professional interests. This educational experience cannot be obtained, duplicated, or simulated in the depth and scope offered by MSH because there is no other forensic facility in the state. For additional information, refer to section on Educational and Training Activities.

Probably the greatest concern from the citizens of the communities is acceptance of such a facility in their community. There has been much concern expressed in the past when relocating Minnesota Security Hospital was being considered before the construction of the present facility in St. Peter.

V. IMPACT ON STAFF - EFFECTS OF CLOSURE

A. Loss of Jobs

1. Family Units Employed

As of June 15, 1982, there were 674 employees working at St. Peter State Hospital in a full-time (573) or part-time (101) capacity. There are 46 married couples employed who would be particularly hard hit in the event of future closure. A total of 628 households would be affected significantly when these working spouses are excluded. The staffing allocation for the institution recently went from 640 FTE to over 702. Future closure would affect the increased number of staff.

2. Age Factors/Alternate Employment

A current survey indicates that the average employee is just under 40 years of age (39.6). Given our agricultural location, there would be few area jobs needing the skills of our hospital/institutional staff. A small number of clerical and skill trades employees could probably find work, but most others would have to relocate to continue their careers or seek employment in a new field. Over one-third of our employees are age 45 or over, and about 24% are age 50 or over. Closure would be particularly difficult for these individuals as suitable future employment might be difficult.

3. Employees with Disabilities

The most recent Affirmative Action Quarterly Report indicates that about 6%, or 41-42 employees, have some type of handicap (including four service workers) which could affect their future employment possibilities adversely.

B. Personnel Related Costs

1. Relocation

There is no accurate way of estimating the number of employees wishing to be relocated in another state agency vs. the number wishing to remain in St. Peter. As a guesstimate, probably 20% would accept a transfer within DPW, with Oak Terrace and Faribault being the preferred

locations. The commuting to and from work would be considerable, but relocations of families would not be immediately necessary. Probably about 5% would accept positions elsewhere in the state government, requiring significant relocation expenses. Relocation costs could total about \$2 million. (700 employees X 25% = 175; 175 X \$10,000 - est'd costs. = \$1,750,000)

2. Unemployment - Dollar Cost

It is estimated that 75% of the employees would need to collect unemployment compensation. Most would collect for most or all of their eligibility periods, as suitable similar work would probably not be available. (525 employees @ \$175 for 26 weeks average = \$2.39 million) Under adverse regional economic conditions, these benefits could be extended for an additional 13 weeks, making our expenses 50% greater, or close to \$3.5 million.

3. Severance Pay

This hospital has one of the lowest employee turnover rates in the DPW hospital system, with an expected turnover rate between only 10-15% in a given year. As a result, many become long-term employees. The average employee tends to use only 70-80% of the accrued sick leave during a given year, so many accumulate significant sick leave balances. It is guesstimated that the state would have to pay a laid-off full-time employee for 160 hours of vacation and 275 hours of sick leave (at 40% of an average of 687 hours).

a. 275 sick leave hours X \$9/hr. X 525 employees = \$1,299,375

b. 160 vacation hours X \$9/hr. X 525 employees = 756,000

\$2,055,375

4. Re-training

As of March, 1982, the unemployment rate for the average of our five surrounding counties (Nicollet, Blue Earth, LeSueur, Brown, and Sibley) was 7.88% and above the state average. There would not be many available fields of work for employee re-training, given this high unemployment rate.

VI. IMPACT ON COMMUNITY - EFFECTS OF CLOSURE A. Economic

1. Hospital Payroll/Operating Budget

a. Percent of City Expenses

It is difficult to estimate the percentage of St. Peter city income coming from the institution's salary budget, as current salary averages are not available for St. Peter alone. Assuming that St. Peter non-institutional averages are the same as the average for Nicollet County in 1980, this institution amounts to about 32.83% of all salaries and wages paid to all employees in St. Peter (\$11,520,000 of \$35,090,000). Since just over half of all employees live in St. Peter, closure could result in a loss of 16-17% of St. Peter residents' total earnings.

b. Percent of County Expenses

The last available salary data were for the calendar year of 1980. Institutional salaries were adjusted for this same period. The institution's payroll amounts to about 8%, of the total income (Minnesota taxable) for all of Nicollet County. It is estimated that the current total would be higher and closer to 10% due to: (1). Increased number of staff here; and (2). Declining farm income which has affected many businesses and other rural taxpayers.

2. Hospital Numbers of Employees

a. Percent of City Employment

3,830 part and full-time city jobs as of December, 1981 (Dept. of Energy, Planning & Development); of these, 702 - or 18.3% - were full-time equivalent hospital positions as of June 15, 1982.

b. Percent of County Employment

14,786 part and full-time employees in Nicollet County, according to 1981 Minnesota County Labor Force Estimates; the 702 hospital positions account for 4.7% of the county employment. Note that most county jobs are farm related and would not be avail-

able to hospital employees in the event of layoffs. Revenue Lost to City

There is no single figure for "dollar expansion" or "multiplier effect" from state jobs available for use. Such figures are usually from 1/6 to 2.5 additional jobs created for each new or existing job within a community. The lower figure is probably more applicable, as large amounts of services and goods are not purchased from our immediate region. There are a large number of "main street" businesses hovering between profit and loss that would probably have to go out of business if this hospital were to close. An estimate in the number of dollars spent locally (St. Peter, Mankato, LeSueur) on an annual basis would be: purchase of supplies, repairs to equipment, and purchase of provisions - \$200,000; utility service to City - \$180,000.00; communications - \$75,000.00; natural gas and fuel oil - \$600,000.00. Also, our residents/patients spend approximately \$55,000.00 of 'their' money locally for personal needs. Due to the current unusual economic conditions, it is likely that a panic effect could raise the number of additional jobs lost to 200 or more.

Effects of Closure on Other Non-hospital Loss in the City/ County

A nearby city, LeSueur, is going through a period of hardship since Pillsbury purchased Green Giant. A number of Green Giant management and staff employees are transferred to locations in the Twin Cities. At this time, the housing in LeSueur is priced 15-25% lower than St. Peter as a result. The same kind of losses could be anticipated in St. Peter with the loss of an even larger number of jobs. The current rental market appears to be roughly in balance with demand. Again rent would have to drop at least 15-25% to attract people from other cities like Mankato, and even then there would be a limit to the number willing to commute elsewhere to work. All citizens would suffer significant paper losses. It is estimated that 2,000 homes worth an average of \$70,000 with a 20% loss in

value would amount to a \$28 million loss in St. Peter real estate. Other nearby smaller towns would also be affected.

St. Peter and its surrounding area could anticipate eventually losing population if 674 or more jobs were to be eliminated. At worst, this could amount to the 2,000+ people in households of hospital employees. Others indirectly affected and laid off in retail and service businesses supported by hospital employee salaries and purchases also would have to seek employment elsewhere. The school population could be reduced by one-fourth or more; a community hospital that is currently "just getting along" would probably have to close; private organizations such as churches, a golf course, and an elementary school could face closure or bankruptcy. Unless some other industry could be found to employ people in the region, closure would be devastating.

B. Community Services - Educational & Training Activities

If St. Peter Regional Treatment Center or sections within the Center were not available for educational field experiences, an important aspect of its provision of services in education and training would not be available. Our programs offer valuable opportunities for students to explore career interests in working with one or more of our disability groups, as well as providing them with on-the-job experiences. Examples of educational opportunities we have offered, and which would no longer be available, are:

1. Vocational-Technical Schools

- a. The Mankato Area Vocational Institute currently uses this hospital for "on-the-job" training for technicians planning to work in nursing homes or hospitals. There are no other large hospitals which can provide such training in this region. The class can be conducted in a single location for a combination of work and classes. At least 24-25 are in each class, needing the "hands-on" experience we can provide. A smaller number of vocational students are sometimes placed

in other fields such as clerical/secretarial as well, but the numbers are changing from year to year. Two-week internships are also utilized for LPN students, and four-week internships are available for Human Service Technician students. b. The Faribault Area Vocational Technical Institute sends 40-50 LPN trainees twice a year for a practicum in MI/CD training.

2. Professional Education (Graduate & Undergraduate)

a. Mankato State University

Students have placements in the fields of vocational rehabilitation, social work, psychology, nursing, recreational therapy, music, education and special education.

b. Gustavus Adolphus College

Students have placements in the fields of sociology, psychology, and music.

c. St. Olaf College

Chaplaincy training has been utilized for students.

3. Other Governmental Units

The Hospital Staff Development Department offers training sessions for employees of other governmental agencies and private nursing homes largely supported by governmental financing in the region. Each year hundreds of hours of such training are secured here because it is not available elsewhere or available only at much greater expense. Recent discussions have been held with a professor of neurology at the Mayo Medical School, concerning the availability of St. Peter Regional Treatment Center as a site for a brief field experience. In addition, the Mankato Area Vocational Technical Institute has made inquiries regarding the possible use of this campus for LPN clinical training and experience.

The foregoing information presents a picture of educational experiences which cannot be obtained, duplicated, or simulated in the depth and scope offered by the St. Peter Regional Treatment Center because no other state facility has this unique combination of disability groups as a source of learning.

VII. ALTERNATE TREATMENT RESOURCES

Chemical Dependency

A. Primary In-Patient

Facilities located in Albert Lea, Rochester, Cannon Falls, and Mankato. There are no extended in-patient programs.

B. Out-Patient Treatment

Services are available in Mankato, Winona, Rochester, and Waseca - in addition to a number of private mental health professionals in the larger communities.

C. Halfway Houses

Several programs are located in Mankato, Fairmont, Austin, Rochester, Winona, and Owatonna.

D. Board and Care

Several homes are located in Rochester, New Ulm, Austin, Fairmont, and Mankato.

Mental Illness

A. Halfway Houses

One each in Mankato, Rochester, and Winona.

B. Crisis Centers

C. Two facilities are currently available in Waseca and Albert Lea. Mental Health In-Patient Units

Only two hospitals in Rochester and Mankato offer a full treatment program.

D. Day Treatment

Services are available in Austin and Mankato as well as two day care centers in Winona and Rochester.

E. Sheltered Workshops/Vocation Rehabilitation Services

Services are located in several communities. A number of these facilities have branch services in neighboring locations. Rochester, Winona, Red Wing, Austin, Albert Lea, Owatonna, Mankato, Fairmont, and New Ulm

F. Mental Health Centers

Owatonna, Austin, Albert Lea, New Ulm, Rochester,
Winona, Mankato, and Fairmont.

Mental Retardation

A. Residential

Group living facilities are located in all
counties of the receiving area other than
Nicollet.

B. Day Achievement Centers

Services are available to residents in all 11
counties in the receiving area.

C. Sheltered Workshops/Work Activity

Work activities services are available through
workshops in Mankato and their branches in New
Ulm and Fairmont. Some Day Achievement Centers
also provide work activity services by contract
with the Mankato Rehabilitation Center.

Alternate Treatment Facilities Within the Receiving Area

Minnesota Security Hospital

- Prison (about 15% of MSH patients)
- Halfway Houses
- Crisis Centers
- Mental Health Units
- Day Treatment Facilities
- Sheltered Workshops

There are no alternative treatment facilities available in the state that would deal effectively with MSH patients due to their need for a highly controlled, structured setting. Commitments to MSH are received because the above facilities are not able to deal with our patient population due to their aggressive, uncontrollable behaviors and inability to handle a less structured, unsupervised setting.

If MSH were not available to the community and court systems, the county jails would have to house our patients, and this would be unrealistic. State "open" hospitals are usually resistive to accepting transfers as are community based treatment programs, even when the patient has had time to stabilize and show progress and is felt ready to be released into a less structured environment.

MSH continues to have great difficulty in finding placement alternatives because of the need for highly structured and supervised programs in the community setting.

MSH has used placement facilities in the metro area (Hennepin and Ramsey counties). However, with funds becoming increasingly harder to obtain for the county, less welfare assistance is available for placements. County welfare departments are becoming very resistive to accepting anyone from outside their county of legal settlement, therefore, decreasing the resources available even further.

ST. PETER REGIONAL TREATMENT CENTER

PROJECTED POPULATION GROWTH

County	Census 1980*	Projected Census 1990	% Change
Blue Earth**/**	52,314	54,200	+ 3.6
Brown **/**	28,645	30,600	+ 6.8
Carver**	37,046	43,600	+17.7
Dodge***	14,773	13,600	- 7.9
Faribault**/**	19,714	18,700	- 5.1
Fillmore***	21,930	21,200	- 3.3
Freeborn***	36,329	37,900	+ 4.3
Goodhue***	38,749	44,500	+14.8
Houston***	19,617	19,200	- 2.1
LeSueur**/**	23,434	23,000	- 1.9
Martin**/**	24,687	25,100	+ 1.7
Mower***	40,390	43,400	+ 7.5
Nicollet**/**	26,929	26,600	- 1.2
Olmsted***	91,971	112,200	+22.0
Rice***	46,087	49,100	+ 6.5
Scott**	43,784	51,700	+18.1
Sibley**	15,448	16,000	+ 3.6
Steele***	30,328	32,000	+ 5.5
Wabasha***	19,335	20,000	+ 3.4'
Waseca**/**	18,448	19,100	+ 3.5
Watonwan**/**	12,361	11,800	- 4.5
Winona***	46,256	46,000	- 0.6
Totals	708,575	759,500	+ 7.2

Note: The Minnesota Security Hospital receives patients from all

87 counties; the statewide census comparison is as follows:

Census 1980	Projected Census 1990	% Change
4,077,148	4,329,700	+ 6.2

* The 1980 census is included for all counties currently listed in our catchment area, although we didn't officially begin receiving admissions from Region X until June, 1981.

** Denotes MVSAC catchment area

*** Denotes SPSH (MI-CD) catchment area

The projected 1990 census was obtained from data prepared by the Minnesota State Demographer's Office; document entitled, "Revised Minnesota County Population Projections",.

St. Peter Regional Treatment Center In-house
Population as of June 20, 1982 and Admissions July 1,
1981 through May 31, 1982

County	In-house Total on June 20, 1982	July 1, 1981 through May 31, 1982 - Total Admissions								
		MI	CD	MSH	MVSAC	MI	CD	MSH	MVSAC	Total
Aitkin	1			1				1		
Anoka	8			8				4		4
Becker	3			3				2		2
Beltrami	5			5						
Benton	1			1				3		3
Blue Earth	70	22	11	3	34	23	98	2	9	132
Brown	40	15	2	2	21	6	35	3	3	47
Carlton	3	1		2				2		2
Carver	13	2			11			1	2	3
Cass	2			2				2		2
Chippewa	1				1					
Chisago	1			1				2		2
Clay	1			1				2		2
Cook	1			1				2		2
Crow Wing	2			2				2		2
Dakota	8			8				8		8
Dodge	4	3		1		3	5	1		9
Faribault	23	1	1	1	20		18	1	1	20
Fillmore	5	1	4			4	10	1		15
Freeborn	14	6	4	3	1	11	53	2		66
Goodhue	8	5	3			8	10	3		21
Hennepin	77	15		58	4			44		44
Houston	2	2				4	10	1		15

County	In-house Total on June 20, 1982	July 1, 1981 through May 31, 1982 - Total Admissions								
		MI	CD	MSH	MVSAC	MI	CD	MSH	MVSAC	Total
Itasca	5			4	1			4		4
Jackson	2				2			1		1
Lake of the Woods								2		2
LeSueur	31	9	4	1	17	11	39	2	2	54
Lyon	1			1				1		1
McLeod	2				2					
Mahnomen	2			2						
Martin	29	17	1	2	9	11	20	3	1	35
Meeker	1			1				2		2
Mille Lacs	1				1					
Mower	17	11	4	1	1	15	8	3		26
Murray	2			1	1					
Nicollet	29	13	4		12	19	27	3		49
Nobles	3	1			2			1		1
Norman	1			1						
Olmsted	29	19	4	6		23	51	4		78
Otter Tail	1			1				4		4
Pennington	3			3				2		2
Pine								6		6
Polk	1			1				1		1
Pope								1		1
Ramsey	25	5		20				20		20
Redwood								1		1
Renville	3				3			2		2
Rice	6	3	3			17	15	5		37

County	In-house Total on June 20, 1982	July 1, 1981 through May 31, 1982 - Total Admissions								
		MI	CD	MSH	MVSAC	MI	CD	MSH	MVSAC	Total
Scott	17	2			15			3	4	7
Sherburne	3			3				1		1
Sibley	12	1			11				1	1
Stearns	9			9				9		9
Steele	9	6	2	1		11	4	1		16
Stevens								1		1
St. Louis	14			14				20		20
Todd	1			1				1		1
Traverse	1			1						
Wabasha	5	1	1	3		4	19	3		26
Waseca	11	4	2		5	5	26	2	3	36
Washington	2	1		1				1		1
Watonwan	12	5			7	3	21	2	1	27
Winona	2	1	1			4	27	3		34
Wright	2			2				2		2
Non-resident	9			9				11		11
Totals from Receiving Area	549	144	51	192	162	182	496	217	27	922
Totals from Outside Receiving Area	47	28	0	0	19	21	8	0	2	31
Grand Totals	596	172	51	192	181	203	504	217	29	953

St. Peter State Hospital In-house Population as of
June 20, 1982 and Admissions July 1, 1981 through May 31, 1982

County	In-house Total on June 20, 1982	July 1, 1981 through May 31, 1982 - Total Admissions				
		MI	CD	MI	CD	Total
Blue Earth	33	22	11	23	98	121
Brown	17	15	2	6	35	41
Dodge	3	3		3	5	8
Faribault	2	1	1		18	18
Fillmore	5	1	4	4	10	14
Freeborn	10	6	4	11	53	64
Goodhue	8	5	3	8	10	18
Houston	2	2	0	4	10	14
LeSueur	13	9	4	11	39	50
Martin	18	17	1	11	20	31
Mower	15	11	4	15	8	23
Nicollet	17	13	4	19	27	46
Olmsted	23	19	4	23	51	74
Rice	6	3	3	17	15	32
Steele	8	6	2	11	4	15
Wabasha	2	1	1	4	19	23
Waseca	6	4	2	5	26	31
Watsonwan	5	5		3	21	24
Winona	2	1	1	4	27	31
Totals from Receiving Area	195	144	51	182	496	678
Totals from Outside Receiving Area	28	28		21	8	29
Grand Totals	223	172	51	203	504	707

Minnesota Security Hospital In-house
Population as of June 20, 1982 and Admissions July 1,
1981 through May 30, 1982

County	In-house Total on June 20, 1982	July 1, 1981 through May 31, 1982 - Total Admissions - MSH
Aitkin	1	1
Anoka	8	4
Becker	3	2
Beltrami	5	
Benton	1	3
-Blue Earth	3	2
Brown	2	3
Carlton	2	2
Carver		1
Cass	2	2
Chisago	1	2
Clay	1	2
Cook	1	2
Crow Wing	2	2
Dakota	8	
Dodge	1	1
Faribault	1	1
Fillmore		1
Freeborn	3	2
Goodhue		3
Hennepin	58	44
Houston		1
Itasca	4	4
Jackson		1
Lake of the Woods		2
LeSueur	1	2
Lyon	1	1
Mahomen	2	
Martin	2	3
Meeker	1	2
Mower	1	3
Murray	1	
Nicollet		3

County	In-house Total on June 20, 1982	July 1, 1981 through May 31, 1982 -Total Admissions - MSH
Nobles		
Norman	1	4
Olmsted	6	4
Otter Tail	1	2
Pennington	3	6
Pine		1
Polk	1	1
Pope		20
Ramsey	20	1
Redwood		2
Renville		5
Rice		3
Scott		1
Sherburne	3	9
Stearns	9	
Steele	1	1
Stevens		20
St. Louis	14	1
Todd	1	
Traverse	1	3
Wabasha	3	2
Waseca		1
Washington	1	2
Watonwan		3
Winona		2
Wright	2	11
Non-resident	9	217
Totals	192	

Minnesota Valley Social Adaptation Center
 In-house Population as of June 20, 1982 and Admissions July 1,
 1981 through May 30, 1982

County-	In-house Total on June 20,	July 1, 1981 through May 31, 1982 -Total Admissions - MVSAC
Blue Earth	34	9
Brown	21	3
Carver	11	2
Faribault	20	1
LeSueur	17	2
Martin	9	1
Nicollet	12	
Scott	15	4
Sibley	11	1
Waseca	5	3
Watonwan	7	1
Totals from Receiving Area	162	27
Totals from Outside Receiving Area	19	2
Grand Totals	181	29

St. Peter State Hospital - MI & CD
 Length of Stay by Disability July
 1, 1981 - May 31, 1982

MI		CD	
LOS in Days	Persons in Group N= 166	LOS in Days	Persons in Group N= 508
under 30 days	28.3%	under 7 days	11.0%
31-60 (1-2 mos)	8.4%	7-14 (1-2 wks)	9.0%
61-90 (2-3 mos)	7.2%	15-21 (2-3 wks)	5.3%
91-180 (3-6 mos)	17.5%	22-28 (3-4 wks)	24.4%
181-365 (6-12 mos)	15.7%	29-35 (4-5 wks)	29.3%
366-730 (1-2 yrs)	12.7%	36-42 (5-6 wks)	9.4%
731-1095 (2-3 yrs)	2.4%	43-49 (6-7 wks)	3.3%
1096-U60 (3-4 yrs)	1.8%	50-56 (7-8 wks)	2.2%
1461-1825 (4-5 yrs)	1.2%	over 56 (over 8 wks)	6.1%
over 1825 (over 5 yrs)	4.8%		

Minnesota Security Hospital
 Length of Stay by Disability
 July 1, 1981 - May 31, 1982

LOS in Days	On Evaluation*	On Hold Order*	In Treatment	
	Persons in Group N= 108	Persons in Group N= 6	LOS Days/Yrs.	Persons in Group N=84
under 7 days	1.9%	16.7%	under 30 days	9.5%
7-14 days	12.0%	33.3%	30-60 days	2.4%
15-21 days	14.8%	33.3%	61-90 days	10.7%
22-28 days	3.7%		91-180 days	17.8%
29-35 days	6.5%		181-365 days	13.1%
36-42 days	6.5%		1-2 yrs.	19.0%
43-49 days	20.4%		2-3 yrs.	13.1%
50-56 days	12.0%		3-4 yrs.	3.6%
57-63 days	6.5%	16.7%	4-5 yrs.	4.8%
64-70 days	4.6%		5-6 yrs.	3.6%
over 70 days	11.1%		6-7 yrs.	2.4%
			7-8 yrs.	
			over 8 yrs.	

*length of stay from date of admission to date returned to Court

St. Peter Regional Treatment Center
Admissions and Discharges
1974 - 1981

Fiscal Year	Admissions					Discharges				
	MI	CD	MSH	MVSAC	Total	MI	CD	MSH	MVSAC	Total
1973-74	165	365	145	18	693	190	364	153	82	789
1974-75	185	352	198	57	792	171	306	194	59	730
1975-76	152	301	180	25	658	174	262	166	50	652
1976-77	180	404	177	21	782	131	360	145	58	694
1977-78	157	371	202	13	743	155	380	143	54	732
1978-79	165	488	218	17	888	190	490	215	20	915
1979-80	161	453	249	29	892	166	437	230	26	859
1980-81	167	514	247	19	947	162	512	256	37	967
Eight-year Average	167	406	202	25	800	167	389	188	48	792
1982 to May 31	203	504	217	30	954	167	508	211	19	905

St. Peter Regional Treatment Center
County Utilization

County	January 1, 1980-December 31, 1980								In-house as of June 20, 1982				January 1, 1981-December 31, 1981							
	Admissions				Discharges				MI	CD	MSH	MVSAC	Admissions				Discharges			
MI	CD	MSH	MVSAC	MI	CD	MSH	MVSAC	MI					CD	MSH	MVSAC	MI	CD	MSH	MVSAC	MI
Aitkin			1				2				1								1	
Anoka			6				6				8								11	
Becker			1				1				3								1	
Beltrami			4				3				5								1	
Benton			2				1				1								5	
Blue Earth	42	105	7	17	29	107	8	17	22	11	3	34	28	116	4	8	39	115	3	4
Brown	17	32		1	18	36	1	2	15	2	2	21	10	36	4	3	10	34	3	1
Carlton			1				1				2				4				2	
Carver	6	17	2	1	6	18	2	1				11	7	18	1	2	7	17		4
Cass			4				3				2				4				7	
Chisago			2								1				3				1	
Clay			3				2				1				2				2	
Clearwater			1																1	
Cook											1				1					
Cottonwood			1				1												4	
Crow Wing			4				5				2				3				4	
Dakota			5				4				8				6				5	
Dodge		1	1			1			3		1		2	5	1		2	4	1	
Douglas			2				2								1				2	
Faribault	9	26	1		7	31			1	1	1	20	1	19	2	1	7	20	2	
Fillmore		2			2	2			1	4			4	7	1		1	6		
Freeborn			2		1		1		6	4	3		5	19	1			16	1	
Goodhue		2	1		2	1			5	3			3	5	1		1	4	1	
Hennepin			48				37				58				55				56	

County	January 1, 1980 - December 31, 1980								In-house as of June 20, 1982				January 1, 1981-December 31, 1981							
	Admissions				Discharges				MI	CD	MSH	MVSAC	Admissions				Discharges			
MI	CD	MSH	MVSAC	MI	CD	MSH	MVSAC	MI					CD	MSH	MVSAC	MI	CD	MSH	MVSAC	MI
Polk							2				1				2				1	
Pope															2				2	
Ramsey			17				16				20				20				23	
Redwood															1				1	
Renville							1								1					
Rice		5	1			5	1		3	3				4	8	3		2	5	3
Rock			1				1													
Scott	11	36	2	5	8	33	1	3				15	11	29	2	4	15	36	2	3
Sherburne			4				3				3				1				1	
Sibley	6	20	1		5	18		2				11	7	15		1	11	14		1
Stearns			6				1				9				12				11	
Steele		2	3			1	3		6	2	1		8	3	1		4	3		
Stevens			1												1					
St. Louis			7				8				14				23				14	
Todd			1				1				1								1	
Traverse											1									
Wabasha		1	3			1	2		1	1	3		2	7	2		2	6	1	
Waseca	1	41	2	2	2	40		2	4	2		5	6	31	2	4	3	30	2	3
Washington			1				1				1				2				3	
Watonwan	6	24	3		4	22	1		5				7	24	1		6	25	3	
Wilkin															1				1	
Winona		7	5			6	6		1	1			2	16	3			17	2	
Wright			5				5								1				2	
Non-resident			10				18								11				11	
Totals from Receiving Area	141	472		26	120	470		29	144	51		162	177	531		26	169	519		17
Totals from Outside Receiving Area	9	15			14	16		1	28			19	23	7		2	11	9		2
Grand Totals	150	487	217	26	134	486	203	30	172	51	192	181	200	538	252	28	180	528	232	19

St. Peter State Hospital
County Utilization

County	January 1, 1980-December 31, 1980				In-house as of June 20, 1982		January 1, 1981-December 31, 1981			
	Admissions		Discharges		MI	CD	Admissions		Discharges	
	MI	CD	MI	CD	MI	CD	MI	CD	MI	CD
Blue Earth	42	105	29	107	22	11	28	116	39	115
Brown	17	32	18	36	15	2	10	36	10	34
Carver	6	17	6	18			7	18	7	17
Dodge		1		1	3		2	5	2	4
Faribault	9	26	7	31	1	1	1	19	7	20
Fillmore		2	2	2	1	4	4	7	1	6
Freeborn			1		6	4	5	19		16
Goodhue		2		2	5	3	3	5	1	4
Houston		1		1	2		3	2	1	2
LeSueur	11	51	7	50	9	4	17	50	20	47
Martin	23	41	20	39	17	1	17	32	20	32
Mower					11	4	8	2		1
Nicollet	8	45	11	43	13	4	15	45	13	51
Olmsted	1	13		14	19	4	10	42	5	34
Rice		5		5	3	3	4	8	2	5
Scott	11	36	8	33			11	29	15	36
Sibley	6	20	5	18			7	15	11	14
Steele		2		1	6	2	8	3	4	3
Wabasha		1		1	1	1	2	7	2	6
Waseca	1	41	2	40	4	2	6	31	3	30
Watonwan	6	24	4	22	5		7	24	6	25
Winona		7		6	1	1	2	16		17

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County	January 1, 1980-December 31, 1980				In-house as		January 1, 1981-December 31, 1981			
	Admissions		Discharges		of June 20, 1982		Admissions		Discharges	
	MI	CD	MI	CD	MI	CD	MI	CD	MI	CD
Totals from Receiving Area	141	472	120	470	144	51	177	531	169	519
Totals from Outside Receiving Area	9	15	14	16	28		23	7	11	9
Grand Totals	150	487	134	486	172	51	200	538	180	528

County	Minnesota Security Hospital County Utilization		In-house as of June 20, 1982	January 1, 1981-December 31, 1981	
	January 1, 1980-December 31, 1980 Admissions	Discharges		Admissions	Discharges
Aitkin	1	2	1	1	1
Anoka	6	6	8	6	11
Becker	1	1	3	2	1
Beltrami	4	3	5		1
Benton	2	1	1	3	5
Blue Earth	7	8	3	4	3
Brown		1	2	4	3
Carlton	1	1	2	4	2
Carver	2	2		1	
Cass	4	3	2	4	7
Chisago	2		1	3	1
Clay	3	2	1	2	2
Clearwater	1				1
Cook			1	1	
Cottonwood	1	1			
Crow Wing	4	5	2	3	4
Dakota	5	4	8	6	5
Dodge	1		1	1	1
Douglas	2	2		1	2
Faribault	1		1	2	2
Fillmore				1	
Freeborn	2	1	3	1	1
Goodhue	1	1		1	1

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County	January 1, 1980-December 31, 1980		In-house as of June 20, 1982	January 1, 1981-December 31, 1981	
	Admissions	Discharges		Admissions	Discharges
Hennepin	48	37	58	55	56
Houston	1	1		1	1
Hubbard	1	2			
Isanti	1				
Itasca	3	6	4	9	5
Jackson	2	2		2	1
Kanabec	1			1	2
Kandiyohi		2		1	
Kittson					1
Koochiching	3	3		2	3
LeSueur	1		1	3	3
Lyon			1	2	1
McLeod	1	1			
Mahnomen			2		
Martin	3	4	2	5	3
Meeker		1	1	3	2
Mille Lacs		1		1	1
Morrison	2	1		1	2
Mower			1	3	3
Murray	1	1	1		
Nicollet	4	5		5	2
Norman			1		
Olmsted	12	12	6	8	5
Otter Tail	2	3	1	2	1
Pennington	2	2	3	1	
Pine	5	3		4	2
Pipestone		1			

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County	January 1, 1980-December 31, 1980		In-house as of June 20, 1982	January 1, 1981-December 31, 1981	
	Admissions	Discharges		Admissions	Discharges
Polk		2	1	2	1
Pope				2	2
Ramsey	17	16	20	20	23
Redwood				1	1
Renville		1		1	
Rice	1	1		3	3
Rock	1	1			
Scott	2	1		2	2
Sherburne	4	3	3	1	1
Sibley	1				
Stearns	6	1	9	12	11
Steele	3	3	1	1	
Stevens	1			1	
St. Louis	7	8	14	23	14
Todd	1	1	1		1
Traverse			1		
Wabasha	3	2	3	2	1
Waseca	2			2	2
Washington	1	1	1	2	3
Watsonwan	3	1		1	3
Wilkin				1	1
Winona	5	6		3	2
Wright	5	5	2	1	2
Non-resident	10	18	9	11	11
Totals	217	203	192	252	232

Minnesota Valley Social Adaptation Center
County Utilization

County	January 1, 1980-December 31, 1980		In-house as of June 20, 1982	January 1, 1981-December 31, 1981	
	Admissions	Discharges		Admissions	Discharges
Blue Earth	17	17	34	8	4
Brown	1	2	21	3	1
Carver	1	1	11	2	4
Faribault			20	1	
LeSueur		1	17	2	
Martin			9		
Nicollet			12		1
Scott	5	3	15	4	3
Sibley		2	11	1	1
Waseca	2	2	5	4	3
Totals from Receiving Area	26	29	162	26	17
Totals from Outside Receiving Area		1	19	2	2
Grand Totals	26	30	181	28	19

EDUCATIONAL AFFILIATIONS

Educational institution/agency	Affiliated Field
Faribault AVTI, Faribault, MN	Licensed Practical Nursing Program
Mankato AVTI, Mankato, MN	Human Services Program Clinical Experience Internship Licensed Practical Nursing Program Internship Clinical Experience - contacts made regarding this Clerical/Secretarial
Mankato State University, Mankato, MN (undergraduate and/or graduate programs)	Nursing Vocational Rehabilitation Interns Social Work Interns Psychology Interns Recreational Therapy Interns Music Interns Therapeutic Recreation Interns Special Education (student teaching) Community Counseling Interns
Gustavus Adolphus College, St. Peter, MN	Social Services Interns Psychology Interns Music Interns
St. Olaf's College, Northfield, MN	Chaplaincy training
Mayo Medical School, Rochester, MN	Medical Students (contact has been made)
Univ. of Minnesota Internship Consortium, Minneapolis, MN	Dietary Interns
St. Mary's Hospital, Minneapolis, MN	Occupational Therapy Interns
St. Catherine's College, Minneapolis, MN	Occupational Therapy Interns
North Dakota State School of Science, Waupaton, ND	Occupational Therapy Interns
Univ. of Minnesota, Minneapolis, MN	Therapeutic Recreation Interns

(Continued)

EDUCATIONAL AFFILIATIONS

Educational Institution/Agency	Affiliated Field
St. Peter Interdistrict Cooperative (High School Vocational Program) St. Peter, MN	Health Careers Program (Career Exploration)
Federal Government -Comprehensive Employment Training Act - (CETA)	Human Services training in Basic Health Care and other on-the-job experiences and training

PROJECTED REIMBURSEMENT OFFICE REPORT

07/01/82 thru 06/30/83

	Mentally Ill	Mentally Retarded	Chemical Dep.	TOTAL
MEDICAL ASSISTANCE (XIX)	810,716	5,497,767	107,158	6,415,641
MEDICARE (XVIII)	136,821	815	17,962	155,598
PRIVATE INSURANCE	111,699	0	137,272	248,971
OTHER (Private pay, etc.)	501,833	279,286	40,251	821,370
GRAND TOTALS	1,561,069	5,777,868	302,643	7,641,580
SPRTC COSTS	73.08	84.67	83.29	78.96 (Average)

The per capita cost of care charged by D.P.W. is 87.95 per day; the above figures of per diem costs for SPRTC are costs submitted to Medicare per contract with the State of Minnesota.

Projection is based on actual reimbursement collection reports of 07/01/81 thru 05/31/82 - and projected for a twelve-month period.

The average per diem cost of \$78.96 above is slightly higher than the average per diem cost contained in Department Budget/Expenditures/Encumbrance Report (B.E.E.). The Reimbursement Office per diem average costs include items not considered in the B.E.E. Report such as depreciation on hospital buildings and equipment, bonding costs, operational costs of central office, etc.